Print Reset form

NOTIFICATION OF HEALTH INSURANCE COVERAGE
A.R.S. § 43-210

Health Care Insurer Name:		
Health Care Insurer Address Number and Street or PO Box:		
City:	State	ZIP Code
Contact Person Name	Contact Person Phone Number	
NAIC #	Federal Identification #	

I have completed this Notification. I declare that to the best of my knowledge and belief, this information is true, correct and complete.

Signature _____ Date _____

(a) INSURED NAME	(b) CERTIFICATE NUMBER	(c) DATE INSURANCE COVERAGE WAS APPLIED FOR	(d) DATE INSURANCE COVERAGE WAS OBTAINED	(e) DATE INSURANCE COVERAGE COMMENCED	(f) COVERAGE RECEIVED	(g) STATUTORY CREDIT ALLOWANCE	(h) 50% OF ANNUAL HEALTH INSURANCE PREMIUM	(i) ALLOWABLE CREDIT (Lesser of Column e or f)

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
INSURED NAME	CERTIFICATE NUMBER	DATE INSURANCE COVERAGE WAS APPLIED FOR	DATE INSURANCE COVERAGE WAS OBTAINED	DATE INSURANCE COVERAGE COMMENCED	COVERAGE RECEIVED	STATUTORY CREDIT ALLOWANCE	50% OF ANNUAL HEALTH INSURANCE PREMIUM	ALLOWABLE CREDIT (Lesser of Column e or f)